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Hide and Seek: Elmer Belt, Agnes, and the Battle over Castration in Transsexual Surgery, 1953–1962

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ABSTRACT: In the 1950s, the idea of sex change increasingly assumed the mainstay of public interest. As psychiatrists and psychologists developed new understandings of gender, the role of surgeons is often overlooked in the early history of sex reassignment. This article explores the work of one such doctor, Elmer Belt, a urologist based in Los Angeles. Between 1953 and 1962, Belt operated on twenty-nine male-to-female patients in the face of ethical and material obstacles. Working closely with Harry Benjamin, Belt developed a surgical technique that transplanted the testes inside the abdomen rather than involving full castration. He became involved in the famous case of Agnes Torres, on which other high-profile scientists based their invention of such seminal concepts as "passing" and "gender identity." Belt's utilization of Agnes as exemplary evidence to support his technique illustrates how and why testicular retention remained a heated topic in the development of transsexual science.

KEYWORDS: Elmer Belt, Harry Benjamin, Agnes Torres, transsexualism, surgery, castration, cryptorchidism, transtopia

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Historians have depicted the 1950s as a watershed turning point in transgender history.[1] The decade saw high-profile individuals taking deliberate measures to promote new understandings of gender and encourage greater acceptance of "sex change." By that point, endocrinologist Harry Benjamin (1885–1986) had refined the concept of *transsexualism*, distinguishing it from the older category of *transvestism*.[2] The wider public learned about the feasibility of sex reassignment primarily through the story of Christine Jorgensen (1926–89). After receiving her gender-confirming surgery in Denmark, Jorgensen appeared in media as an iconic celebrity and returned to the United States in December 1952.[3] The Christine saga quickly evolved into a global template for gender transition, reaching as far as Japan, Mexico, Taiwan, and Israel in the

[1] Joanne Meyerowitz, *How Sex Changed: A History of Transsexuality in the United States* (Cambridge, Mass.: Harvard University Press, 2002); Susan Stryker, *Transgender History* (Berkeley, Calif.: Seal Press, 2008); Barry Reay, *Trans America: A Counter History* (Cambridge: Polity, 2020).

[2] Harry Benjamin, "Transvestism and Transsexuality," *Internat. J. Sexol.* 7 (1953): 12–14. On the global reception of Benjamin's work, see Howard Chiang, *Transtopia in the Sinophone Pacific* (New York: Columbia University Press, 2021), 19–63; Emmanuel David, "Sonic Transness: Christine Jorgensen's Vocal Performance in *Kaming Mga Talyada (We Who Are Sexy)*," *Amer. Quart.* 75, no. 1 (2023)*:* 75–102. On the history of cross-dressing, see Vern L. Bullough and Bonnie Bullough, *Cross-Dressing, Sex, and Gender* (Philadelphia: University of Pennsylvania Press, 1993). The researcher often associated with the invention of "transvestism" as a sexological category is Magnus Hirschfeld (1868–1935). See Magnus Hirschfeld, *Transvestites: The Erotic Drive to Cross Dress* (1910; repr., Buffalo, N.Y.: Prometheus, 1991). British sexologist Havelock Ellis (1859–1939) proposed the term "sexo-aesthetic inversion" to address the affective and emotional sphere of inversion not captured by Hirschfeld's "transvestism." See Havelock Ellis, "Sexo-Aesthetic Inversion," *Alien. & Neurol.* 34, no. 2 (1913): 249–79.

[3] I am cognizant that "gender-confirming surgery" is an anachronistic concept in the context of the 1950s. I adopt this to deflect the more damaging and pathologizing lexicon used more frequently back then. This article employs terms such as transsexual, transgender, trans, sexual minorities, sex change, conversion operation, MTF, and so forth sometimes interchangeably to refer to individuals who wish to alter their bodily sex via some kind of medical intervention, but I use them in specific ways that maintain fidelity to the archival sources as much as possible. Similarly, my pronoun usage, though never perfect, is informed by the available context gleaned from the relevant archival material.

short span of a year and a half.[4] In this narrative, doctors and patients alike played a proactive role in shaping the contours of history.

However, as we have learned from Hayden White, narratives do not put an end to our knowledge about the past. If anything, they suggest the need to trouble our complacency, "open[ing] up a prospect on the past that inspires more study."[5] An established narrative, often fictive in disposition, conceals more than it reveals. In the recent move to "decolonize" trans studies, scholars have begun to rethink the merit of the version of transsexual history described above.[6] Aren Z. Aizura, for instance, has called attention to transnational mobility as a form of social capital privileging certain queer subjects over others.[7] C. Riley Snorton has critiqued the racialized amnesia conditioned by the Jorgensen narrative, especially its silence on the

[4] Mark McLelland, *Queer Japan from the Pacific War to the Internet Age* (Lanham, Md.: Rowman & Littlefield, 2005); Ryan M. Jones, "Mexican Sexology and Male Homosexuality: Genealogies and Global Contexts, 1860–1957," in *A Global History of Sexual Science, 1880–1960*, ed. Veronika Fuechtner, Douglas E. Haynes, and Ryan M. Jones (Oakland: University of California Press, 2017), 232–57; Howard Chiang, *After Eunuchs: Science, Medicine, and the Transformation of Sex in Modern China* (New York: Columbia University Press, 2018); Gil Englestein and Iris Rachimimov, "Crossing Borders and Demolishing Boundaries: The Connected History of the Israeli Transgender Community, 1953–1986," *J. Mod. Jewish Stud.* 18, no. 2 (2019): 142–59; Ryan M. Jones, "'Now I Have Found Myself, and I Am Happy': Marta Olmos, Sex Reassignment, the Media and Mexico on a Global Stage, 1952–7," *J. Lat. Amer. Stud.* 55 (2023): 455–89.

[5] Hayden White, *Figural Realism: Studies in the Mimesis Effect* (Baltimore: Johns Hopkins University Press, 1998), 7.

[6] For important discussions of the decolonizing perspective in trans studies, see, e.g., Susan Stryker, "De/Colonizing Transgender Studies of China," in *Transgender China*, ed. Howard Chiang (New York: Palgrave Macmillan, 2012), 287–92; Aniruddha Dutta and Raina Roy, "Decolonizing Transgender in India: Some Reflections," *TSQ: Transgender Stud. Quart.* 1, no. 3 (2014): 320–36.

[7] Aren Z. Aizura, *Mobile Subjects: Transnational Imaginaries of Gender Reassignment* (Durham, N.C.: Duke University Press, 2018).

indispensable role of Black subjects in queer history.[8] Jules Gill-Peterson's work unveils the figure of the child as a driving force in the history of trans medicalization.[9] To unsettle much of the U.S.-centrism plaguing the field, my previous work offered different genealogies of transness in the Sinophone Pacific through the lens of transtopia, an epistemological worldview that makes room for different scales of gender transgression that are not always recognizable through the Western notion of transgender.[10] This article extends this thread of revisionism to rethink the foundations of trans history.

In fact, even in Western trans history, examples that exceed a narrative closure of transgender abound. Perhaps one of the most often cited examples is two-spirit individuals in native American societies. Their gender and sexual transgression bear a historically embedded and politically contested relationship—mediated by settler colonialism—to the modern formulation of lesbian, gay, bisexual, and transgender identities.[11] By returning to the 1950s as a pivotal juncture in trans medicine, I question the historical applicability of the category of transgender by focusing on the experience of those for whom transness was defined around the politics of castration. This article denaturalizes the narrative tenor of trans historicity by exposing the way it conceals subjects whose surgical experience did not conform to conventional

[8] C. Riley Snorton, *Black on Both Sides: A Racial History of Trans Identity* (Minneapolis: University of Minnesota Press, 2017).
[9] Jules Gill-Peterson, *Histories of the Transgender Child* (Minneapolis: University of Minnesota Press, 2018).
[10] Chiang, *Transtopia in the Sinophone Pacific* (n. 2).
[11] Scott L. Morgensen, *Spaces Between Us: Queer Settler Colonialism and Indigenous Decolonization* (Minneapolis: University of Minnesota Press, 2011).

understandings of transsexuality, the role of surgeons in mediating that experience, and the continuing impact of endocrinology in midcentury sexual medicine.[12]

In the context of medicine, the instability of transness emerges out of the iterative negotiations between the doctor and the patient, both of whom reposition themselves evolvingly and interactively. Into the 1950s, some transgender individuals (and their surgeons) considered orchidectomy and penectomies to constitute the actual "sex change," while viewing vaginoplasty as an optional "plastic" or "cosmetic" step. "In light of such accounts," Susan Stryker and Nikki Sullivan observed, "contemporary transsexual discourses that focus on the transformation of one normative genital morphology into another normative genital morphology appear as complex, historically contingent, narrative productions that mask the disarticulations and dismembered parts from which the narrative has been assembled."[13] Similar to the interest of those who demanded varying degrees of bodily "amputation," the agency of surgeons has remained largely unexplored by historians of trans medicine. This article seeks to remedy a myopia of "work in transgender studies," which has "more often ignored or deflected the surgical question than engaged with it."[14] While it is true that endocrinologists and psychiatrists played a leading role in the development of sexological science in the first half of the twentieth century, a shift in focus to the kind of knowledge embodied in surgical techniques sheds light on a register of medicine

[12] Susan Stryker and Aaron Aizura, "Introduction: Transgender Studies 2.0," in *Transgender Studies Reader 2*, ed. Susan Stryker and Aaron Aizura (New York: Routledge, 2013), 1–12; Leah DeVun and Zeb Tortorici, "Trans, Time, and History," *TSQ: Transgender Stud. Quart.* 5, no. 4 (2018): 518–39.
[13] Susan Stryker and Nikki Sullivan, "King's Member, Queen's Body: Transsexual Surgery, Self-Demand Amputation, and the Somatechnics of Sovereign Power," in *Somatechnics: Queering the Technolisation of Bodies*, ed. Nikki Sullivan and Samantha Murray (Surrey: Ashgate, 2009), 49–63, quotation on 55.
[14] Eric Plemons and Chris Straayer, "Introduction: Reframing the Surgical," *TSQ: Transgender Stud. Quart.* 5, no. 2 (2018): 164–73, quotation on 164.

often missing in trans history.[15] As Eric Plemons and Chris Straayer have insisted, "It is important to pay attention to the practices of trans surgery, the contexts and conditions in which it happens, the professional and institutional networks in which it is carried out, the techniques employed in its name, and the understandings of sex, gender, and indeed trans itself that its practices enact."[16]

The enduring legacy of endocrinological theory in midcentury trans surgery can be seen in the work of Elmer Belt (1893–1980), a urologist who quietly performed genital operations against the larger tide of his profession (Figure 1). Born in Chicago, Belt spent the majority of his life in Southern California and was known for helping to found the School of Medicine at the University of California, Los Angeles (UCLA). After receiving his M.D. in San Francisco, Belt returned to Los Angeles to establish a private practice in 1923, followed by the Elmer Belt Urological Group—which occupied its own building at 1893 Wilshire Boulevard—in 1936. It was from this base that Belt ventured into the horizon of conversion operations in the early 1950s (Figure 2). Working closely with Benjamin, Belt developed a surgical technique that did not include castrating male-to-female (MTF) patients and would instead transplant their testes inside the abdomen. He supported this approach with a theory that assigned to gonadal secretion paramount importance in personality and psychological development. If a transsexual desired

[15] Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis* (New York: Basic Books, 1981); Nelly Oudshoorn, *Beyond the Natural Body: An Archaeology of Sex Hormones* (London: Routledge, 1994); Jennifer Terry, *An American Obsession: Science, Medicine, and Homosexuality in Modern Society* (Chicago: University of Chicago Press, 1999); Vernon Rosario, *Homosexuality and Science: A Guide to the Debates* (Santa Barbara, Calif.: ABC-CLIO, 2002); Chandak Sengoopta, *The Most Secret Quintessence of Life: Sex, Glands, and Hormones, 1850–1950* (Chicago: University of Chicago Press, 2006).

[16] Plemons and Straayer, "Introduction" (n. 14), 166.

bodily change with a sex gland already present, Belt reasoned, the need to remove the organ was not readily evident. Whereas dominant depictions of trans history consider the 1950s as a critical point when the psychiatric paradigm of gender identity displaced the gonadal model of sex constitution, Belt's work suggests that the gonadal model retained a strong influence over transsexual medicine, especially in the surgical realm, into the 1960s.[17]

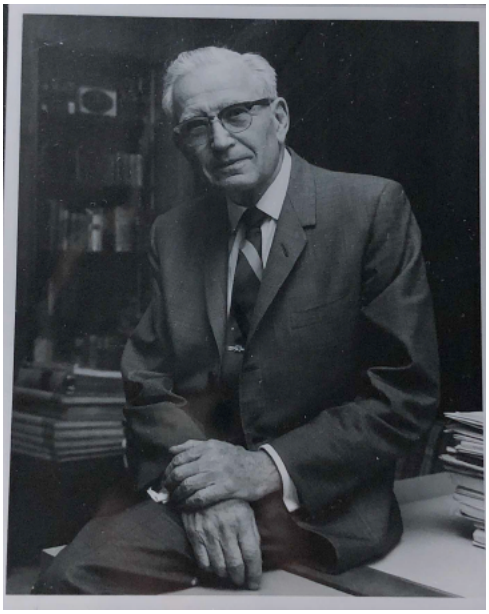

Figure 1. Elmer Belt, Elmer Belt Papers (Manuscript Collection 66). Library Special Collections for Medicine and the Sciences, Louise M. Darling Biomedical Library, UCLA.

[17] John Money, "Hermaphroditism, Gender, and Precocity in Hyperadrenocorticism," *Bull. Johns Hopkins Hosp.* 96 (1955): 253–64; Bernice Hausmann, *Changing Sex: Transsexualism, Technology, and the Idea of Gender* (Durham, N.C.: Duke University Press, 1995); Sandra Eder, *How the Clinic Made Gender: The Medical History of a Transformative Idea* (Chicago: University of Chicago Press, 2022).

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Figure 2. Elmer Belt Urological Group Physical Quarters, Elmer Belt Papers (Manuscript Collection 66). Library Special Collections for Medicine and the Sciences, Louise M. Darling Biomedical Library, UCLA.

The focus on Belt's surgical involvement enriches the history of medical uncertainty surrounding trans health care. As Beans Velocci and Stef Shuster have convincingly shown, doctors like Benjamin and Belt routinely acted as "gatekeepers" of trans medicine by sorting out worthy patients from those whom they deemed unworthy of care.[18] On the one hand, physicians substantiated the category of transsexual by applying it to individuals who they thought fitted the criterion of having sex-change desire. On the other, they often blocked access to treatment because they considered the same patients undeserving of surgery. This circular and illogical

[18] Beans Velocci, "Standards of Care: Uncertainty and Risk in Harry Benjamin's Transsexual Classifications," *TSQ: Transgender Stud. Quart.* 8, no. 4 (2021): 462–80; and Stef M. Shuster, *Trans Medicine: The Emergence and Practice of Treating Gender* (New York: New York University Press, 2021).

reasoning remained impenetrable from the patient's perspective. Building on this insight, I seek to peel back the layers of calculus behind the doctor's interest in working with trans patients at a moment when great uncertainty—both conceptually and procedurally—existed surrounding the most appropriate course of action. Historicizing the nascent context in which surgery increasingly assumed salience in the medical management of transness offers a more well-rounded impression of the different variables defining the parameters of uncertainty. Surgeons were not merely technicians working on behalf of psychiatrists or other medical professionals, but they acted as care providers who followed their own professional logic and pursued their own professional interests where ethics and emotions often played a role. A focus on trans surgery thus opens an analytical horizon to assess the way doctors' ambition and patients' desire coevolved over time. In an era before the Erikson Educational Foundation (founded in 1963) and the Johns Hopkins Clinic (founded in 1966), the mechanisms of collaboration and antagonism that characterized patient-doctor relations calibrated new forms of trans embodiment.

If critical revisionism demands a different ordering of historical knowledge in which a range of subject positions not outweighed by the contemporary notion of transgender identity can be readily acknowledged, this article mines a body of archival sources that contain some of the missing pieces for renarrativizing the meaning of transness. The methodology employed in this study involves a comprehensive reading of personal correspondences between Benjamin, Belt, their peers, and their patients in the 1950s and 1960s. Such a deliberate move also places Belt and his motivation in broader historical context.[19] Belt deserves to be seen as a key interlocutor

[19] For a critical perspective on Benjamin and Belt that explores the ways in which their practice was damaging and transphobic, see Velocci, "Standards of Care" (n. 18).

in transgender sexology in the mid-twentieth century; his involvement in sex-change operations lasted a decade, culminating in the case of Agnes Torres (b. 1939), and the trail of his private correspondences offers a rich glimpse into his work, his relationship to other professionals, his interactions with patients, and the ethical and material challenges he faced. Belt's work has largely been overlooked by historians, likely due to the fact that he did not publish his thinking and findings in this area. Yet this correspondence and the obstacles he encountered provide important clues for understanding the position of surgeons in the development of transsexual science and the contexts in which they assessed patients, developed diagnoses, and determined what care to authorize or provide.

Moreover, it is possible to glean from this contextualization a spectrum of actors who may not fit the contemporary notion of transgender but were no less invested in pushing doctors like Belt to experiment with new medical ideas and practices. These include individuals who sought surgical intervention for varying degrees of genital alteration and patients who trusted Belt's approach and agreed to keep rather than removing their gonads. From this spectrum of trans subjectivity followed a gradation of testicular removal and transplantation practice. By attending to the ways in which scientific understandings of sex changed over time, this article argues for the formation of a distinct surgical logic of trans identity in the mid-twentieth century. According to this novel logic, the ideal of preserving as much tissue as possible and the reigning import of the gonads in trans health care stood in stark contrast to the interwar-era norm of performing castration on individuals deemed sexually abnormal.

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Ethical Wars at the Dawn of Transsexuality

In the early 1950s, Belt saw a handful of patients who wanted to change their sex. Some were referred to him by Benjamin; others were not. Not all patients got what they asked for. Belt did not automatically operate on anyone who showed up in his clinic. Sometimes, he saw the situation as too complicated, sometimes he suggested that no operation was needed.[20] At other times, the patient simply turned to other doctors, such as Dr. Daniel Lopez Ferrer of Mexico.[21] But Belt was committed to surgery and fought hard to find ways to accommodate this clinical practice within legal and financial constraints. On December 16, 1953, Belt performed his first sex reassignment surgery on two MTF patients; one was forty-six years old and another forty-three. These operations involved the plastic removal of the penis and vaginoplasty.[22] According to Belt, one of the vaginoplasties was a "failure" because the vaginal pouch "rapidly closed" after the operation. This led him to conclude that "the inversion of the penile skin is a much better method and is permanent."[23] Between July and September in the following year, Belt accepted two more MTF patients from Benjamin—a forty-year-old J. S. and a fifty-seven-year-old A. D.—and operated on them.[24] When they reached out to Belt, both already had their

[20] Harry Benjamin to Elmer Belt, December 15, 1954, Dr. Elmer Belt folder 34, box 23, series IIC, Harry Benjamin Collection (hereafter HBC), Kinsey Institute for Research in Sex, Gender, and Reproduction, Indiana University, Bloomington.
[21] Elmer Belt to Harry Benjamin, December 18, 1954, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.
[22] Elmer Belt to Harry Benjamin, April 15, 1963, folder 11, box 25, series IIC, HBC.
[23] Elmer Belt to Harry Benjamin, December 18, 1954, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.
[24] To protect the privacy of patients, I anonymize all archival correspondences except for those penned by people whose identity is already publicly known.

testicles removed (J. S. received her orchiectomy in Holland). Building on preceding experience, Belt amputated the penis and constructed an artificial vagina for the two patients.[25]

These early efforts notwithstanding, Belt confronted a complex array of hopes and desires coming from his patients. "In spite of good plastic results," Belt wrote, "[A. D.] keeps complaining about everything and expresses great dissatisfaction because there isn't a uterus with tubes and ovaries and ability to have a baby attached to the operation." The incongruence between the doctor's and the patient's expectation suggests that in the early history of sex reassignment surgery, both parties were still in the process of figuring out what was feasible and what was not. As Velocci has argued, one of the most detrimental aspects of early trans medicine came from its distrust of transsexuals as experts on their own needs.[26] Yet the expectation of some trans patients to be able to "have a baby" after surgery reveals a more complicated dynamic, in which transsexuals' self-expertise often called out the existing limitations of health care treatment. Rather than being frustrated with this outright, doctors like Belt could have acknowledged this incongruence as an opportunity to restructure patient relations.

Another major source of distress came from the demand of employment assistance. In an age when sex conversion did not automatically lead to a corresponding change in social and legal recognition, many transsexuals encountered difficulty in finding a job. Sometimes they considered this the doctor's responsibility, which quickly became a source of frustration. After their seemingly successful surgeries, for example, both A.D. and J. S. "called on . . . and denounced" Belt's medical team, because the latter "did not obtain employment for [A. D.]." In

[25] Elmer Belt to Harry Benjamin, April 15, 1963, folder 11, box 25, series IIC, HBC.
[26] Velocci, "Standards of Care" (n. 18), 476.

fact, Belt's standing was "nearly ruined" when he tried to find a job for A. D. at a company, as she "went out there demanding, pushing, utterly unpleasant." Belt discerned, "Trouble is sure to accrue from that source." While acknowledging that such incidents could happen to non-transsexuals as well, he considered such basis for distress "truly . . . a great problem."[27]

Despite having ventured into unfamiliar terrains and received no guideline from peers, Benjamin and Belt remained sympathetic to the suffering of their patients and fought to find ways to make surgery an option. They weighed the ethical implications of transsexual treatment prudently. Put in an unprecedented position (Benjamin had just coined the term "transsexualism" in 1953), what was the best course of action? In their correspondence, Benjamin and Belt showed genuine concern over the rightful way to address the needs of their patients. While "deeply sorry that some of these cases have become a source of annoyance and perhaps worry," Benjamin reiterated his belief that surgery was the best solution to the problems transsexuals faced.

> I feel very strongly that psychiatry can do nothing for these people. We doctors cannot cure them. Are we therefore not justified to at least make their lives a little happier? Must we be bound by emotional prejudices, by unrealistic laws, or by medical politics to simply leave these people to their fate? I sometimes feel ashamed of our profession to stand by and let some of these people mutilate themselves in desperation or occasionally commit suicide.[28]

Benjamin routinely came up against the view of psychiatrists, especially psychoanalysts, who dismissed the value of operations.[29] Despite Belt's unpleasant experience, Benjamin maintained that "from the strictly medical (sexological) point of view, some of these patients ought to be

[27] Elmer Belt to Harry Benjamin, December 18, 1954, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.
[28] Harry Benjamin to Elmer Belt, December 15, 1954, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.
[29] Meyerowitz, *How Sex Changed* (n. 1).

operated on." He found it "dreadful" that "the medical profession, and especially some psychiatrists and analysts refuse to agree to such operations although they readily admit that they have no cure for transsexuals." If these experts could not come up with a solution, on what ground could they really consider themselves men of medicine? Benjamin pressed, "Do they really consider patients only as objects of study and tests? Don't they think they are entitled to treatment too?"[30]

Yet, they knew, obstacles abounded. Perhaps the biggest hurdle lay in the realm of law. Neither Benjamin nor Belt was naïve about the legal ramifications of transsexual surgery. In 1954, the University of California Committee on Transvestism decided against encouraging its doctors to perform "sex change" operations for "the attempted relief of emotional problems," partly due to "public sentiment and legal and religious complications." In explaining the committee's decision to Benjamin, Belt pointed out the absence of legal protection for both his school and the patients: "The attorneys felt that if such an individual altered from masculinity should happen to be arrested during the use of our ladies public toilet under suspicion of being a man, no legal power could prevent a conviction." Moreover, an occurrence like this "might throw the University right into the middle of a public controversy and trial which the people of the community would hugely enjoy and which would rebound with great discredit to the University."[31] Benjamin responded candidly by criticizing this verdict as a missed opportunity: "This committee would have had a chance in the name of science and medicine (that is supposed to help patients) to effect a revision of illogical legal statutes or at least of their rigid

[30] Harry Benjamin to Elmer Belt, January 3, 1955, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.
[31] Elmer Belt to Harry Benjamin, February 21, 1955, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.

enforcement." For Benjamin, the committee ignored the interest and happiness of the patients in favor of conforming to "legal technicalities and religious prejudices."[32] The distance in priority between the committee and Benjamin (and likely Belt) highlights the various stakes involved in competing medical opinions at a time when conversion operations had yet been widely accepted as a legitimate practice.

While it would seem that the possibility for Belt to continue these operations at UCLA had ceased, he operated, with the assistance of a plastic surgeon by the name of Dr. Ruch, on five more patients between twenty-seven and fifty-seven years old in 1956.[33] Nevertheless, Belt soon felt that his work with transsexual patients was not sustainable. Even though he had devised a surgical procedure that did not involve testicular excision, which relieved him of legal culpability, Belt sensed an increasing measure of emotional and financial pressure. In summer 1956, he told Benjamin that "Doctor Ruch and I believe that no matter what we do for these patients they will never be satisfied." Having overseen six such surgeries, Belt complained that the patients always approached him with further requests (surgery, employment assistance, etc.) after the completion of each procedure. This "makes the job of dealing with them and handling their problem very difficult."[34]

In principle, we might expect a doctor like Belt to help a patient with minimal reservation, especially given the scarcity of public resources available to trans individuals. In Belt's mind, however, the issue was complicated by a pattern in which the medical expenses

[32] Harry Benjamin to Elmer Belt, March 8, 1955, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.
[33] Elmer Belt to Harry Benjamin, August 20, 1956, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.
[34] Elmer Belt to Harry Benjamin, February 21, 1955, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.

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were never fully reconciled. This placed significant financial burden on Belt, and it left him with little leverage to either persuade his colleagues to continue to operate or find a location for the procedure even if he succeeded in convincing them. At a time when health insurance companies lacked experience in dealing with such bills, this made "the financial situation . . . extremely trying." Although Belt

> went to lengthy troubles to have the Blue Cross and Blue Shield certify these patients before [admitting] them into the hospital for their plastic repairs, neither of these organizations have paid the hospital bills rendered them. They are evidently restudying the problem and each of these patients . . . overran their insurance protection to the sum of two or three hundred dollars, none of which had been paid in spite of their elaborate and extravagant promises beforehand, so all in all it makes the situation very bad business. Every member of my Staff thinks that I am completely crazy to put up with it and I guess I am.

Toward the end of July 1956, Belt announced that he would "wait a while" before undertaking more of these operations.[35] It is noteworthy that Belt's decision was not solely motivated by the deliberation of the University of California Committee on Transvestism, which disintegrated as soon as it delivered its opinion. Rather, he became hesitant due to a combination of factors: a range of follow-up requests for which the end sight increasingly became a questionable target, the lack of financial support (from insurance companies and patients alike), and the resulting challenge in maintaining a workable environment. None of these ethical and material considerations can be taken lightly in the implementation of a new type of medical treatment.

In the eyes of the doctors, no other variable played a larger role in the determination of surgical suitability than the patient's mental well-being. Since the kind of surgery they wished to pursue was opposed by most psychiatrists, Benjamin and Belt had to tread carefully, sometimes

[35] Elmer Belt to Harry Benjamin, July 29, 1956, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.

by working with specific mental health experts whom they could trust. They took sex reassignment surgery as a serious, irreversible commitment. As such, Benjamin and Belt saw assessing a patient's mental health status/history as an essential prelude to surgery and considered such stability necessary for the patient's ability to sustain a safe postoperative life. Any sign of psychological volatility gave them pause, not the least because, as Velocci has pointed out, the mental health visit served as a means of distributing culpability in the case of a lawsuit.[36]

This soon proved to be the norm, rather than the exception, as well as a source of discouragement for Belt. In July 1957, Belt informed Benjamin that the White Memorial Hospital, where he used to work, had opened its door for him to carry out sex-reassignment procedures.[37] The arrangement was formalized through the effort of his colleagues Theodore Bergman and Roger Barnes. It allowed Belt to operate his first case at White Memorial, with the assistance of Bergman, on January 29, 1958.[38] Benjamin became excited about this new surgical destination and began sending patients to Los Angeles again. Unfortunately, the first patient at White Memorial, according to Belt, "while [doing] very well physically, became mentally berserk in the second week of his post operative period." The patient "threw books, water glasses and everything on his bedside table out into the hall." Although Belt did not explain the reason

[36] Velocci, "Standards of Care" (n. 18).
[37] Elmer Belt to Harry Benjamin, July 21, 1957; Elmer Belt to Harry Benjamin, July 23, 1957, both in Dr. Elmer Belt folder 34, box 23, series IIC, HBC.
[38] Elmer Belt to Harry Benjamin, February 10, 1958, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.

for this behavior, he thought that it was "a great misfortune to have this happen with this new hospital connection for the performance of these operations."[39]

Indeed, in an era before the protocol for transsexual treatment was standardized, surgeons like Belt and Bergman and endocrinologists like Benjamin chose to proceed with caution. One of the psychiatrists whom Belt frequently consulted was Carroll Carlson. Carlson worked with a Psychoanalytic Clinical Committee from her clinic in Beverly Hills. Belt often referred patients to Carlson for a psychological assessment prior to making a decision about surgery. In some cases, when she and her Clinical Committee believed that the patient in question "could grow into a charming, attractive young woman," she would give them "a green light." But in the case of B. C., from Texas, Carlson considered the patient to be "using femininity as a club with which to beat father over the head, successfully."[40] While B. C., in Belt's eyes, "looked so attractive in women's clothes and so well suited to them," he similarly concluded that B. C. was "a very volatile and non-dependable person."[41] And Benjamin concurred: "[B. C.] is one of the most 'dangerous cases.' I say at present, HANDS OFF. . . . He is a very disturbed person and may need hospitalization."[42] After examining B. C. several times with care and caution, Benjamin ultimately decided not to endorse surgical treatment. In his letter to Belt, Benjamin advised, "It may be wise, Elmer, if you tell [B. C.] that, unfortunately, you have not yet received my consent to the operation."[43] When another mutual patient, L. W., threatened to commit suicide unless

[39] Elmer Belt to Harry Benjamin, March 7, 1958, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.
[40] Carroll C. Carlson to Elmer Belt, May 20, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.
[41] Elmer Belt to Harry Benjamin, May 26, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.
[42] Harry Benjamin to Elmer Belt, June 2, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.
[43] Harry Benjamin to Elmer Belt, April 7, 1958, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.

Belt agreed to operate, it suggested to Belt that "the patient would be dangerous if things did not go exactly to his liking. It gives me very cold feet about taking him on as an operative possibility." Eventually, Belt carried out the procedure for L. W. on May 21, 1958, but this happened only after he felt more comfortable with L. W.'s state of mind.[44]

To Remove or Not to Remove: The Politics of Castration

In 1956, Belt began to advocate a form of conversion operation that did not involve the removal of testicles, or orchiectomy, in MTF patients.[45] Instead, he would plant the gonads inside the abdomen before proceeding with the next step. Rather than a bona fide castration, then, what Belt's method achieved was known as cryptorchidism, a condition in which the testes were retained in the abdomen rather than, as in normal development, having descended into the scrotum. Belt was adamant in defending this step in MTF conversions. In his correspondence with B. C.'s gynecologist in Texas, Belt explained, "The testicles are left in place because they retain the faulty interstitial cells which caused this mischief in the first place and we do not remove them because it is not necessary to disturb the patient's endocrine balance to maintain his condition as a trans-sexual since the faulty tissues lay within the substance of the testis in the first place."[46] Belt hinted at the possibility that the gonads held, in part if not in full, the biological secret of transsexualism ("the faulty interstitial cells which caused this mischief in the

[44] Elmer Belt to Harry Benjamin, April 15, 1963, folder 11, box 25, series IIC, HBC.
[45] Four out of the five conversion operations Belt performed in 1956 involved the implantation of the testes into the abdomen. Elmer Belt to Harry Benjamin, April 15, 1963, folder 11, box 25, series IIC, HBC.
[46] Elmer Belt to Robert P. McDonald, June 2, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.

first place"). By "mischief," Belt presumably meant the feeling of being out of place in one's body and the desire for surgery. This technique, surprising nearly every physician who first heard about it, gave Belt some leeway to sidestep legal liability, particularly the kind that would prevent him from castrating otherwise physically healthy bodies in California.

Into the 1960s, Belt pioneered his cryptorchidism approach while navigating the various problems and ethics in conversion operations, which he performed quietly first at the White Memorial Hospital followed by the Hollywood Presbyterian Hospital in 1958 and the Doctor's Hospital in Beverly Hills in 1960.[47] An example of how he maneuvered the intricacies of transsexual treatment can be seen in the case of E. H., a college professor from New London, Virginia, whom Belt monitored for five years but never operated on. In March 1958, Benjamin introduced E. H. to Belt as "the most interesting and fascinating case I have ever had under treatment and observation."[48] At Benjamin's suggestion, E. H. wrote to Belt to introduce himself on May 1, 1958.[49] In his letter, E. H. explained that he was hormonally treated by Benjamin for the third time in a year, and despite his intention to undergo operation, he "[did] not really hope to cross the line and live as a woman, owing to a realistic appraisal of [his] height and masculinity." It is unclear if Benjamin viewed E. H. as a true transsexual or, indeed, if E. H. fits our contemporary notion of transgender. Nevertheless, E. H. stated upfront that what he desired

[47] Elmer Belt to E. H., December 1, 1958, Elmer Belt, 1958–1959 folder; Elmer Belt to Harry Benjamin, July 1, 1960, Elmer Belt, 1959–1962 folder, both in box 3, series IIC, HBC.
[48] Harry Benjamin to Elmer Belt, March 3, 1958, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.
[49] I use the masculine pronoun to refer to E. H. in accordance with the archival record and since he made explicit his interest in appearing as a man in public even after surgery. However, it should be noted that E. H. did eventually undergo surgery in 1963. Whether E. H. carried on to live as a woman afterward is unclear.

most was "an operation for the implanting . . . of ovaries and of a uterus."[50] To this Belt responded, "This is an accomplishment for the future perhaps, but at present it is not within the realm of surgical possibility."[51] Benjamin had apparently "tried to discourage this idea of his but to no avail as his desire is dictated by an emotion and not by reason."[52]

With the possibility of ovarian transplantation called off, Belt's cryptorchidism approach surfaced as the focus of their extended correspondence. E. H. said to Belt five months after they first met,[53] "I need to know whether you will do the 'entire operation,' that is, the orchiectomy. If not, I shall have to continue the effort to find someone to do it first."[54] In ten days, without having received a reply from Belt, E. H. clarified in a follow-up letter, "I do not insist . . . if you now consider it too risky legally, I shall accept your verdict." E. H. explained that his priority was the conversion operation, and only after consulting with Benjamin, who seemed to favor orchiectomy, did he come to this request. "The only bad aspect of leaving [the testicles] in," suspected E. H., "is that I shall have to continue taking such large (and expensive) amounts of estrogen."[55] E. H. may have acquired this impression from speaking to Benjamin. A month later, E. H. asked Belt to "instigate a correspondence between the two of you that would lead to agreement as to whether, in my case, it were better to perform orchiectomy as part of the operation."[56] Interestingly, Benjamin would dispute "[E. H.'s] reference to a disagreement

[50] E. H. to Elmer Belt, May 1, 1958, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.
[51] Elmer Belt to E. H., May 5, 1958, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.
[52] Harry Benjamin to Elmer Belt, May 9, 1958, Dr. Elmer Belt folder 34, box 23, series IIC, HBC.
[53] Belt saw E. H. in his clinic in Los Angeles for the first time on June 11, 1958. Elmer Belt to Harry Benjamin, June 12, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.
[54] E. H. to Elmer Belt, November 17, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.
[55] E. H. to Elmer Belt, November 27, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.
[56] E. H. to Elmer Belt, December 10, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.

[concerning the need of] castration," a characterization Benjamin viewed as "more based on wishful thinking than on facts."[57]

At a time when doctors suspected that there were factors causing transsexualism that they did not yet fully understand, Belt, a urologist, developed a theory based on the endocrine secretions. Simply put, he thought that since transsexuals developed their condition with the existent sex glands, it did not make sense to disturb their bodily constitution further by removing the testicles. If his cryptorchidism approach led to a positive surgical and psychological outcome, it would suggest that biology—whatever was retained in the submerged testes—contributed to transsexual health. This correlated with the way Benjamin, Jorgensen, and others have framed transsexuals as suffering from a constitutional bisexual condition.[58] At the very least, the gonadal model challenged the more negative view of transsexualism maintained by the psychoanalytic community. Having yet to agree to operate on E. H., Belt explained his reasoning for testicular retention and asked E. H. to refrain from getting an orchiectomy before coming West for surgery.

> Actually since trans-sexual individuals have gotten the way they are with the orchids they have, I can see no reason for objecting to the retention of the hormones which the orchids in such persons are producing. There is certainly something wrong with the chemistry of this production or these individuals would not be as they are. In removing the orchids we create an unbalanced endocrine state which is hard to bring into balance with artificial hormones. You don't know it, of course, but you derive a great portion of your drive and personality from your hormones and the situation of Stilbestrol for these hormones only helps out in small measure in restoring this loss because after all the best of our female hormones do not match up with all of the things which the ovaries produce. There is much that is still not understood about the chemistry of the hormones of both males and females.

[57] Harry Benjamin to Elmer Belt, May 10, 1960, Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC.
[58] Meyerowitz, *How Sex Changed* (n. 1).

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Based on his understanding of castration and its effect, which "produces a sleepy, indifferent, pale, yellowish, slow, unaggressive old fellow who has virtually no interest in life," Belt "detest[ed] removing testicles, particularly in relatively young men."[59] In working closely with endocrinologists such as Benjamin, Belt remained keen on finding out more about the working of sex hormones. His theory was not necessarily anti-trans, but it was simply anti-castration in nature: he hesitated to excise healthy gonads from his patients without knowing the full physiological and psychological implications.

Besides castration, Belt took other hidden repercussions into account. In particular, the patient's long-term employment prospect came to the fore, in part because it may backfire and hurt his own career. After meeting E. H. for the first time on June 11, 1958, Belt picked up the phone immediately and told Benjamin that he was unlikely to operate on E. H. This left Benjamin "somewhat distressed" given that he had encouraged E. H. to seek help in California. Based on their telephone conversation, Benjamin assessed the outcome of a potential operation from the view of three angles: surgical, psychological, and practical. In the case of E. H., Benjamin was confident that Belt's skill would lead to a good surgical outcome, which, according to the evaluation of E. H.'s psychiatrist Robert Laidlaw, would also reinforce a decent mental outcome. For patients like E. H., who "had already experienced a psychological benefit during the period of hormonal feminization," Benjamin remarked, "since the mind could not be adjusted to the body, the body was adjusted to the mind." However, the most troubling aspect of the case, in Benjamin's opinion, concerned the practical consequence, that is, "the prospect of

[59] Elmer Belt to E. H., December 9, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC. Stilbestrol is a nonsteroidal estrogen medication.

producing a reasonably successful 'woman.'"[60] Having discerned his own conspicuous masculine traits, E. H. insisted on continuing to live as a man after surgery, and this raised a red flag. Belt was concerned that "sooner or later E. H. is going to have to undergo physical examination in the course of his work as a teacher." If such an exam ended the patient's teaching career, "his resentment against the man who carried out this work will rise and grow—no matter what thinks of his feeling now." In light of E. H.'s "very masculine" temperament, Belt concluded, "I would almost match him in insanity if I did this job for him."[61]

The doctors' reservations notwithstanding, isolated incidences pointed to an evolving trend of shift in attitude, which Belt and Benjamin acknowledged. In September 1958, for example, one of Belt's patients was caught by an FBI officer for having dodged the draft. Instead of explaining his condition to the police, he ran away. Luckily, the FBI officer showed sympathy and approached Belt for a medical statement. After reading the letter, the judge decided in the boy's favor, understood the justification for not taking his military service, excused him, and sent him back to his job as a hostess in Beverly Hills.[62] Belt happily inferred, "This is evidence that the law in all of its usual harshness and cruelty is recognizing this defect as a justifiable reason for wearing feminine dress and is adopting a merciful attitude toward these lads."[63] In early 1960, Benjamin appeared in court to give a disposition in a small Midwestern town near Chicago. One of his former patients, "Tommie," who had his breast removed and a hysterectomy

[60] Harry Benjamin to Elmer Belt, June 11, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.
[61] Elmer Belt to Harry Benjamin, June 12, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.
[62] The term "boy" is directly drawn from the way the individual in question was described in the archival sources.
[63] Elmer Belt to Harry Benjamin, September 24, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.

done by that point, applied for a change of birth certificate. Benjamin informed the judge that sex could be scientifically interpreted from a number of angles: genetic, anatomical, endocrinological, psychological, social, and rearing/assignment. "After Tommie's treatment," Benjamin explained to the judge, "only the genetic sex could still be called completely female while all the others would be considered either totally or partially male."[64] Following Benjamin's deposition, the judge granted the change of birth certificate. Benjamin expressed gratification upon learning the decision, "Isn't it encouraging that occasionally we encounter an intelligent judge."[65]

Though uncomfortable with E. H.'s insistence on adhering to a masculine social role, the doctors were surprised to learn that some of their patients circumvented a medical exam with success. Such was the case with a patient of Belt's, who was hired as a practical nurse at the Queen of Angels Hospital in 1958. The patient, presumably still in the preoperative stage, attended a mandatory physical exam. Like the other hired nurses, the patient was asked to disrobe for the doctor. The doctor examined the patient's abdomen, chest, extremities, heart, lungs, reflexes, and so forth. But when the patient was put up for a vaginal, "with apparent feminine squeamishness the patient exclaimed 'this is a most unfortunate time, doctor—I am right in the middle of my menstrual period. Can't we do that another time?' The doctor said, 'Oh, it doesn't matter anyway' and thus a full set of magnificent masculine genitals were not revealed to the doctor."[66] The patient became a regular employee at the hospital following the exam.

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[64] Harry Benjamin to Elmer Belt, March 7, 1960, Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC
[65] Harry Benjamin to Elmer Belt, May 10, 1960, Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC
[66] Elmer Belt to Harry Benjamin, September 24, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.

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These exceptions notwithstanding, past experience reminded Benjamin and Belt to anticipate obstacles. Again, the issue of unpaid medical expenses recurred as a cause of concern. After seeing E. H. for the first time in June 1958, for instance, Carlson reported to Belt that E. H. refused to pay her for their consultation.[67] In a letter to Benjamin, Belt expressed irritation: "These transsexuals are certainly the most annoying people. I surely should not have expected this kind of action from [E. H.]."[68] Part of Belt's frustration seemed to originate from the fact that he had not charged E. H. anything for all the time they spent together.[69] As he explained to Benjamin, he "was very sorry that the patient had made this long trip out here without being able to undergo surgery."[70] Even though E. H. eventually paid Carlson,[71] Belt did not forget the implication of this matter. In January 1959, he told Benjamin that he would not consider going forward with E. H.'s operation unless two of his former patients paid up their medical bills at the Hollywood Hospital.[72] Eventually, Belt was no longer able to operate at the Hollywood Hospital and had to carry out the operations in Beverly Hills.

But E. H. had reasons to honor only those payments deemed necessitous. Apart from the often-high amount of medical fees, which added up quickly, Carlson was neither the first nor the only psychiatrist E. H. saw in his journey from Virginia to New York to California. If we were to put ourselves in the shoes of these patients, it is reasonable to assume that they had to watch their

[67] Carroll C. Carlson to Elmer Belt, July 2, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.
[68] Elmer Belt to Harry Benjamin, July 7, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.
[69] Elmer Belt to E. H., July 7, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.
[70] Elmer Belt to Harry Benjamin, December 15, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.
[71] Harry Benjamin to Elmer Belt, July 12, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.
[72] Elmer Belt to E. H., December 1, 1958; Elmer Belt to Harry Benjamin, January 5, 1959, both in Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.

finances guardedly in order to be ready for future expenses, including the cost of the operation itself. In fact, doctors regularly asked for an exorbitant price to perform these surgeries. When an opportunity came up in Madrid in 1959, urologist Alfonso de la Pena initially charged $7,500 for a procedure involving castration and vaginoplasty.[73] Benjamin thought de la Pena's "charges were just too preposterous," and E. H. "wondered if the Professor were suffering from delusions about 'rich Americans.'"[74]

> In response, de la Pena justified his price by spelling out an ethical bind:
> First let me explain, that when a surgeon has to remove some pernici[ous], pathological process, in order to bring comfort or save life, or an organ affected, there is never a question of money, that might prevent a patient of mine, get the best surgical service. But when the part to be removed offers *no physical pathology*, a surgeon is in a different position, to evaluate, the need of physical removal. The only way to evaluate such a need . . . was to charge them.

De la Pena went on to explain his refusal to provide surgery at very low rates: because only if the price reflected the real need of the patient or if the service was offered for free, he believed, could the physician be free of criticism.[75] In some ways, we are back full circle to the politics of castration, a procedure Belt rigidly opposed. Whereas de la Pena was willing to perform orchiectomy but only for a high price, Belt bypassed the issue by replanting the testes inside the abdomen. Whether the approach was to force the patient to come to terms with the psychological need of castration or to alleviate the doctor's legal vulnerability by way of cryptorchidism, the

[73] Elmer Belt to Harry Benjamin, November 2, 1959; Harry Benjamin to Elmer Belt, December 7, 1959, both in Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC.
[74] Harry Benjamin to Elmer Belt, December 15, 1959; E. H. to Elmer Belt, December 26, 1959, both in Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC.
[75] Alfonso de la Pena to E. H., January 7, 1960, Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC, emphasis added.

concern over ethical responsibility assumed an underlying rationale. After a series of negotiations, de la Pena eventually agreed to operate on E. H. for the price of $1,000.[76]

With the money issue resolved, the question of orchiectomy reemerged as the focal point of their discussion. E. H. asked Belt to clarify for de la Pena, who was willing to perform castration, but also for Benjamin and himself, the reasoning behind leaving the testicles inside the body.[77] On April 25, 1960, Belt explained to de la Pena why he favored the cryptorchidism approach: "In this way the preservation of the patient's psychological and biological status can be assured and to each person his psychological and biological status is in effect his personality. No one can predict with any degree of assurance what personality changes will take place when as important as endocrine organ as the testis tissue is totally removed." Belt had certainly put his finger on a glaring problem: no systematic study on the effect of castration on MTF transsexuals with non-castrated patients serving as a control group was available. But this was perhaps not surprising, given that the conversion operations had yet to become a widely accepted practice and controlled trials were not established as a requirement in medical research or surgery at the time.[78] Belt's point was that since the urge to change sex "exists in the face of secreting testicles," he did not consider it "necessary to remove the testicles in order to create a feminization which already exists." In essence, Belt conveyed a seemingly humane presupposition: rather than full-blown testicular removal, it was the doctor's duty to both

[76] E. H. to Elmer Belt, April 15, 1960, Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC.
[77] Ibid.
[78] I thank the journal's anonymous reviewer for pointing this out.

preserve as much the patient's "intellectual and physical drives" and afflict as "less of a physiological mutilation" as possible.[79]

The divergence in opinion among the experts was evident on more than one issue. Frankly put, the doctors had as many questions about surgical intervention as their transsexual patients did. What could be taken as an adequate measure? Experts discussed their views on the best course of action but, in so doing, revealed the suspicions and fears that structured their relationships with patients. In the 1950s, this unfamiliar terrain of medical diagnosis, evaluation, treatment, follow-up, and so forth put the doctors in a delicate position, especially in light of both the broader consensus of their profession, which was not always supportive, and the legal risks involved. This led to, as we saw, their disagreement over the appropriate price for the operation. While Belt charged E. H. nothing for the time spent on his case, de la Pena demanded an outrageous price in advance of meeting. No wonder the patients themselves were often at a loss in dealing with the doctors. Yet if a patient showed any sign of irresponsibility, it also undermined the cooperation of the physicians. For example, when E. H. initially refused to pay Carlson, Belt was alarmed by the possibility that hospital expenses may not be paid later. This would make it even more difficult for him to help similar patients in the future.

It is also clear that while keen to help, the doctors made sure to evaluate those who came to them before doing something permanent. At one point, Benjamin appeared as impatient as E. H. in addressing Belt: "Will you operate [on E. H.] next summer or not? . . . Do give me a

[79] Elmer Belt to Alfonso de la Pena, April 25, 1960, Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC.

clear-cut answer if you can."[80] However, Belt's hesitance was corroborated by his colleague's impression: "Dr. Frank Hinman [of UC San Francisco] seemed quite willing to go ahead with E. H.'s problem until he saw E. H. . . . He felt as I did that here was a man who would most certainly get anyone into trouble who dared to operate upon him."[81] Even though Benjamin suggested that Belt would be protected by psychiatric evaluation, Belt maintained his own calculus. When they came together to prepare E. H. for an operation in Madrid, de la Pena suddenly told them in May 1960 that "due to the enemies that such a surgery might afford me in these moments, I must refuse to operate on the patient."[82] It would be at least three more years before E. H.'s wish was fulfilled. In September 1963, E. H. met Dr. Georges Burou, who carried out the operation in Casablanca.[83]

The Ends of Science

In the late 1950s, no comprehensive data were available on the mental health concerns of transsexuals. "A central reason why providers experience so much uncertainty—both historically and currently—in trans medicine," Shuster notes, "is that they feel like they have little evidence

[80] Harry Benjamin to Elmer Belt, December 30, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.
[81] Elmer Belt to Harry Benjamin, December 15, 1958, Elmer Belt, 1958–1959 folder, box 3, series IIC, HBC.
[82] Elmer Belt to Harry Benjamin, June 1, 1960, Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC.
[83] Harry Benjamin to Elmer Belt, December 5, 1963, Elmer Belt, 1962–1965 folder, box 3, series IIC, HBC. On Georges Burou and his operation in Casablanca, see Alex Bakker, Rainer Herrn, Michael Thomas Taylor, and Annette F. Timm, *Others of My Kind: Transatlantic Transgender Histories* (Calgary: University of Calgary Press, 2020), 163–65.

to draw from."[84] The predominant psychiatric literature simply construed them in a hostile light. Benjamin was an exceptional advocate in the medical community, and even liberal sexologist Alfred Kinsey (1894–1956) reached his limit on the subject of genital transformation.[85] Belt's unwillingness to operate on E. H. on account of alleged mental instability characterized his sober approach. This predated a standard of care, widely accepted later, that required individuals interested in gender-affirming surgery to undergo professional psychological evaluation.[86] Yet without something empirical to rely on before the normalization of such standards of care, Belt was in many ways on his own.[87] It made sense that Belt, unlike other sympathetic doctors who did not need to administer irreversible surgery, proceeded with vigilance and according to the terms with which he felt most comfortable. Belt believed that his entire approach to surgery was firmly grounded in science, in particular, the glandular basis of human sexuality.[88] Gradually, he gathered evidence to support his cryptorchidism technique. The ultimate test case for Belt was triggered by an infamous episode, which embroiled a number of high-profile scientists and, as some have noted, catalyzed the conceptualization of gender identity itself: the case of Agnes Torres.[89]

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[84] Shuster, *Trans Medicine* (n. 18), 4.
[85] Joanne Meyerowitz, "Sex Research at the Borders of Gender: Transvestites, Transsexuals, and Alfred C. Kinsey," *Bull. Hist. Med.* 75 (2001): 72–90.
[86] Meyerowitz, *How Sex Changed* (n. 1), 255; Stryker, *Transgender History* (n. 1), 111.
[87] For a critical reappraisal of the history of the Harry Benjamin Standards of Care, see Shuster, *Trans Medicine* (n. 18); Velocci, "Standards of Care" (n. 18). The Standards of Care have become increasingly contested over time.
[88] Oudshoorn, *Beyond the Natural Body* (n. 15); Adele Clarke, *Disciplining Reproduction: Modernity, American Life Sciences, and the Problem of Sex* (Berkeley: University of California Press, 1998); Sengoopta, *Most Secret Quintessence* (n. 15).
[89] The importance of Agnes's case cannot be overstated. This can be seen in the way experts like Robert Stoller continued to revisit the case from a psychoanalytic angle into the late 1960s. Stoller's changing

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As Belt became involved in the Agnes case, his thinking on the subject of cryptorchidism reached maturity and sophistication. In summer 1960, Belt began to correspond with the San Francisco–based psychiatrist Karl Bowman (1888–1973), who had investigated the problem of sex deviation for the state of California and challenged some of Belt's surgical assumptions. With extensive experience in the study of "sexual deviance," Bowman immediately found an ally in Belt and, later, Benjamin.[90] They connected through a mutual patient, L. N., whom Bowman labeled a "complete invert" because L. N., anatomically male, "considered himself being a woman and is repulsed by the idea of sexual relations with women."[91] Even though Bowman favored an operation, the tide turned against him when L. N. appeared in front of a panel of doctors at the Langley Porter Clinic.[92] According to Bowman's account, L. N. "was so upset and emotional that the group unanimously . . . decided that he was too disturbed emotionally to try this operation on him." "At the presentation," Bowman conceded, "[L. N.] did give the

view of Agnes and gender has been widely received. In addition, recent years have witnessed a resurgence of interest—both academic and popular—in Agnes's story. See, e.g., the documentary *Framing Agnes*, directed by Chase Joynt (Fae Pictures, 2022).

[90] Karl Bowman was affiliated with the Committee for the Study of Sex Variants headed by George Henry in New York in the 1930s and later became the state's medical superintendent in 1947. See Terry, *American Obsession* (n. 15), chap. 6; Henry Minton, *Departing from Deviance: A History of Homosexual Rights and Emancipatory Science in America* (Chicago: University of Chicago Press, 2002).

[91] Karl Bowman to Elmer Belt, July 25, 1960, Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC. On the way psychiatrists still associated cross-gendered individuals with the concept of inversion into the 1960s, see Judd Marmor, ed., *Sexual Inversion: The Multiple Roots of Homosexuality* (New York: Basic Books, 1965).

[92] The Langley Porter Clinic was affiliated with the University of California, San Francisco. The panel involved representatives of surgery, endocrinology, urology, and gynecology.

appearance of a quite mentally sick person."[93] This fitted the profile of those patients for whom Belt considered an operation inappropriate.

However, Bowman presented an alternative finding that disputed what Belt may have assumed about the patient's mental fitness for surgery. Rather than psychologically unfit, the patient was just too nervous and mindful of the tremendous value behind a potential operation. A few hours after the episode, Bowman approached L. N. in private, seeking to clarify what had transpired at the panel. L. N. confessed that "he simply went to pieces because this meant so much to him and he wasn't able to give any sort of coherent statement." After a year and a half, Bowman remained resolute in the judgment that a surgical intervention would turn L. N. into "a happier person."[94] He contacted Belt in that spirit, hoping that Belt would agree to take L. N. on as a patient.

Bowman also called out Belt on his cryptorchidism approach. As their correspondence continued, Bowman raised a concern about the effect of this surgical technique. Bowman's familiarity with the relevant literature suggested that there was a chance of one in six for undescended testicles to develop malignancy. "Do you feel," asked Bowman, "that this is not true for testicles which you transplanted to the abdominal cavity?"[95] In fact, a few months ago, Benjamin had voiced a similar concern as well.[96]

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[93] This was not the first time Bowman advised against a conversion operation. In 1949–50, he worked with Kinsey on a patient named Val Barry (pseudonym), and together they concluded that "it is probable the operation the patient desires would not be of benefit." Quoted in Meyerowitz, "Sex Research" (n. 85), 79.

[94] Karl Bowman to Elmer Belt, July 25, 1960, Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC.

[95] Karl Bowman to Elmer Belt, August 30, 1960, Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC.

[96] Harry Benjamin to Elmer Belt, May 10, 1960, Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC.

Rather than being forced into a corner, Belt took this as an opportunity to elaborate on the scientific justification of his technique. In a long letter, Belt delved into the matter of cancer development in undescended testes. He referenced a study conducted by surgeon Horace E. Campbell in 1959, from which he took the estimation that three per thousand men had undescended testes. Based on statistical calculation, the study concluded that undescended testicles were forty-eight times more likely to develop a tumor than testes that had descended properly in the scrotal sac. However, Belt sharply noted that more studies were needed to investigate the fate of testes that had been surgically brought down to the scrotal sac early in life. If the likelihood decreased to 0.05 percent, which was the accepted figure for the overall incidence of testicular tumor, such a finding would corroborate more or less the normal development of the testis. At the same time, Belt noted the high incidence of infertility rate for cryptorchid patients whose testes had been brought down to the scrotal sac. Citing another study, Belt noticed with greater certainty that there was "no congenital testicular dysgenesis" in this class of patients, meaning that the relationship between their testicular development and tumor formation was inconclusive.[97]

As a urologist, Belt felt right at home in sharing his thoughts on testicular science with his psychiatric and endocrinological peers. The point was to make a distinction between the testes he transplanted back into the patient's abdomen and the undescended testes that had preoccupied the existing literature on potential malignancy. "After all of this is said, the fact remains, that a testis which has found its way into the scrotal sac in the normal process of

[97] Elmer Belt to Karl Bowman, September 6, 1960, Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC.

development is a very different structure than a testis which is undescended and has continued its development and function within the abdominal cavity and so no prediction can be made as to what will happen to a testis when it is returned to the abdominal cavity from factual data drawn from testes which have developed and functioned throughout their life span within the belly cavity." Treating this as a generative moment, Belt, who was "hungry for contact with bright minds who have a sympathetic attitude toward this group of afflicted," introduced Bowman to Benjamin and his work on transsexuals.[98] Knowing that Bowman and his assistant Bernice Engle were interested in the subject, Belt offered to turn over to them the data on his own transsexual patients, case histories of whom had been examined by Kinsey before his death.[99]

The most decisive evidence Belt referenced time and again in support of his cryptorchidism technique—and something that attracted the attention of Bowman and Benjamin—came from the case of Agnes. Agnes, a nineteen-year-old white girl with an attractive feminine appearance, showed up in the Psychiatry Department at UCLA in October 1958. She was referred to psychoanalyst Robert Stoller (1924–91) by a private physician in Los Angeles and presented an intriguing puzzle: she had a normal set of male genitalia despite showing conspicuously feminine secondary sex characteristics. Agnes inhabited a deep-seated female identification and insisted on being seen as a typical woman. She went to Stoller for help,

[98] Ibid. This is Belt's own language for himself.

[99] Karl M. Bowman and Bernice Engle, "Medicolegal Aspects of Transvestism," *Amer. J. Psychiatry* 113, no. 7 (1957): 583–88; Karl M. Bowman and G. H. Crook, "Emotional Changes Following Castration," in *Explorations in the Physiology of Emotions*, ed. Louis Jolyon West and Milton Greenblatt (Washington, D.C.: American Psychiatric Association, 1960), 81–96; Karl M. Bowman and Bernice Engle, "The Medical and Legal Implications of Sex Variations," *Law & Contemp. Problems* 25, no. 2 (1960): 292–308.

hoping to match her anatomy to her mind. In light of her feminization, the doctors asked if she had been taking estrogens, which she denied emphatically. Stoller consulted with his colleagues at UCLA, including sociologist Harold Garfinkel (1917–2011), endocrinologist David H. Solomon (1913–2013), and psychologist Alexander Rosen (1923–2007), and came to the diagnosis of testicular feminization. In 1959, they decided to proceed with a castration operation, and supervised by Belt, the surgical team constructed an artificial vagina with the skin of the amputated penis and labia with the skin of the scrotum.

The story of Agnes immediately became a sensation in the scientific community. On September 25, 1959, Stoller, Garfinkel, and Rosen presented a paper at the Western Division Meeting of the American Psychiatric Association in which they introduced Agnes as an "intersexed patient" who maintained a female identification through a type of behavior they called "passing."[100] The concept of passing, later expanded in Garfinkel's book *Studies in Ethnomethodology* (1967), referred to Agnes's ability to convince others of her "elected sex status" while "providing for the possibility of detection and ruin carried out within the socially structured conditions."[101] Three years later, Stoller's team published another report on Agnes's medical, physical, and endocrinological characteristics in the *Journal of Clinical Endocrinology*

[100] Robert J. Stoller, Harold Garfinkel, and Alexander C. Rosen, "Passing and the Maintenance of Sexual Identification in an Intersexed Patient," *AMA Arch. General Psychiatry* 2, no. 4 (1960): 379–84.
[101] Harold Garfinkel, *Studies in Ethnomethodology* (Englewood Cliffs, N.J.: Prentice Hall, 1967), 118. Garfinkel's theoretical insights provided the foundation for later ethnomethodological approaches to gender. See Suzanne Kessler and Wendy McKenna, *Gender: An Ethnomethodological Approach* (New York: Wiley, 1978); Candace West and Don H. Zimmerman, "Doing Gender," *Gender & Soc.* 1 (1987): 125–51.

and Metabolism, including several clinical pictures of her body.[102] Most importantly, Stoller, in collaboration with his colleague at the UCLA Medical School Ralph Greenson (1911–79), coined the concept of *gender identity*.[103] Whereas Stoller used Agnes as a test case, Greenson developed his ideas through the lens of homosexuality. In their formulation, gender identity reflected a congenital, biological force, "one's sense of being a member of a particular sex."[104] This definition allowed Stoller to make sense of Agnes's psychology despite her bodily constitution. Stoller and Greenson presented their findings at the International Psycho-Analytic Congress in Stockholm in summer 1963 and published their papers in the *International Journal of Psychoanalysis* in 1964. With the concept of gender identity in hand, Stoller distinguished Agnes as an *intersexed* patient due to "lack of caricature, of hostility seen in transvestites and transsexuals."[105] These words reveal some of the underlying transphobic assumptions under which Stoller operated as he came to the idea of gender identity. Solomon, too, consented to the conversion operation only because he thought it corrected an underlying endocrinological problem, rather than establishing a precedent for treating transsexual patients.

The legacy of Agnes's case remains much debated to this day. The controversy centers on a revelation later recounted by Stoller himself: "After having kept it from me for eight years, with the greatest casualness, in mid-sentence, and without giving the slightest warning it was

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[102] Arthur D. Schwabe, David H. Solomon, Robert J. Stoller, and John P. Burnham, "Pubertal Feminization in a Genetic Male with Testicular Atrophy and Normal Urinary Gonadotropin," *J. Clin. Endocr.* 22 (1962): 839–45.
[103] Robert J. Stoller, "A Contribution to the Study of Gender Identity," *Internat. J. Psychoanal.* 45 (1964): 220–26.
[104] Ralph Greenson, "On Homosexuality and Gender Identity," *Internat. J. Psychoanal.* 45 (1964): 217–19, quotation on 217.
[105] Stoller, Garfinkel, and Rosen, "Passing" (n. 100), 380.

coming, she revealed that she had never had a biological defect that had feminized her but that she had been taking estrogens since age twelve."[106] By dropping this bomb, Agnes forced her doctors to reevaluate the scientific inferences formulated from her case history. Least affected was probably Garfinkel's theory of passing, because this sociological theory held its explanatory power with respect to Agnes's ability to pass in the female social role.[107] In fact, the concept even had a reflexive element. Garfinkel came to acknowledge that he was "passing" with Agnes, passing as a sociologist, whose "source of authority" came from "Agnes' methodological practices."[108] In organizing Garfinkel's archive after his death in 2011, multimedia artist Chase Joynt and sociologist Kristen Schilt discovered the files of eight other gender-nonconforming subjects. Why did Garfinkel never write about them? Gill-Peterson has suggested that Agnes's white, middle-class background may have afforded a certain kind of racialized leverage.[109] Historian John Forrester even went so far as to ask, provocatively, "How close is Judith Butler's performative concept of gender to Garfinkel's account of Agnes' passing?"[110]

In contrast, Stoller had to revisit his assumptions about gender altogether. From speaking to Agnes's mother, which became possible only after the revelation, Stoller downplayed his

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[106] Robert J. Stoller, *Sex and Gender: On the Development of Masculinity and Femininity* (New York: Science House, 1968), 135.

[107] When Garfinkel published his 1967 *Studies in Ethnomethodology* (n. 101) he included an appendix in which Agnes's revelation was acknowledged. According to sociologist Kristen Schilt, "While the facts of Agnes's life shifts—her feminization was due to exogenous rather than biological sources—the analytic importance of her case study to ethnomethodology did not." Schilt, "The Importance of Being Agnes," *Symbolic Interaction* 39, no. 2 (2016): 287–94, quotation on 292. Schilt suggests that even though Garfinkel promised to write a sequel to the Agnes study, the sequel never materialized, probably because his theory did not need revision.

[108] Garfinkel, *Studies in Ethnomethodology* (n. 101), 181.

[109] Gill-Peterson, *Histories of the Transgender Child* (n. 9), 138.

[110] John Forrester, *Thinking in Cases* (Cambridge: Polity, 2017), 134.

earlier interpretation of Agnes through the biological force of gender identity. While not "completely exclud[ing] the possibility that some biological force plays a role," Stoller instead advanced an alternative psychoanalytic reading.[111] In *Sex and Gender* (1968), Stoller attributed Agnes's transsexualism to an etiological logic familiar to psychoanalytic accounts of sexual inversion: "too much contact with the mother's body for too long and a father who is psychologically absent."[112] According to Forrester, Agnes served as an exemplary case in the evolution of Stoller's thinking. In reframing Agnes's status from an intersexed to a transsexual patient, Stoller sought to replace Freud's theory of bisexuality with the new vocabulary of gender identity, itself a moving target.[113] Whether from a sociological or a psychiatric standpoint, critics remain divided on the significance of the Agnes case.

Less explored is the exemplary status of Agnes in the surgical side of this history. In his private correspondences, Belt repeatedly came back to his discovery in the Agnes story to support his cryptorchidism method. Unlike Stoller and Garfinkel, Belt identified Agnes as a *transsexual* patient at the outset. Belt's involvement in Agnes's surgery convinced him of the importance of testicular retention. Upon analysis, Agnes's excised testicles contained large amounts of estrogen, but Belt questioned the naturalness of the unusual estrogen presence from the start. In line with his theory of transsexuality, Belt supported cryptorchidism in order to maintain Agnes's endocrinological health. However, with her sex glands removed, a procedure that Solomon insisted on executing, Agnes was immediately plunged into a menopausal

[111] Stoller, *Sex and Gender* (n. 106), 139.
[112] Ibid., 138.
[113] Forrester, *Thinking in Cases* (n. 110), 127–39.

syndrome. Since the surgical angle of Agnes's story remains the least understood, Belt's recollection of the procedure, never published, is worth quoting in full.

> I had been called in consultation to see her at the University of California Medical School Hospital. The patient declared that no Stilbestrol had ever been taken. I doubted this at the time and expressed my doubts in the presence of the patient, but the patient smiled up sweetly and said, "I'm quite honest with you, Doctor." This patient was feminine in all possible respects except for the possession of well-formed testes and a well-formed penis. Dr. Solomon had seen the patient, our leading endocrinologist at the University of California at Los Angeles. Dr. Solomon is particularly interested in aberrations in the sex hormones but Dr. Solomon has been adamant about not operating transsexuals. On this particular occasion he gave his consent for the removal of the external genitalia and the creation of an artificial vagina. Of course, I held out for the retention of the testes, at least one of them, basing my assertion on the fact that the patient had developed to her present extent with these testes and therefore the hormones she was receiving from them were abnormal in that they had created the desire to be feminine and had given her a feminine body. I therefore saw no logic in removing them. I was pretty firm about this and very definite in my statements, but, of course, after all, Doctor Solomon was the individual who held the reins and he told the intern on the urologic service who did the job to take off the testes. Thus the testes were obtained for a study of their estrogen-androgen content. . . . Our urologic intern asked me help him in the operation; instead I carefully outlined the operative procedure for him and then stood behind him as he worked, directing his movements. A very good job resulted . . . but Dr. Solomon was very careful not to let this be a precedent and seems to have been satisfied with the finding of a very great estrogen content in these testicles as proof that the operation was a physiological necessity and not in response to a whim of the patient.[114]

Diverging from Solomon's impression, Belt took away from the incident the fact that the patient would be better off *without* the excision of the testes—the menopausal syndrome was avoidable. Because Agnes's "femininity" was later restored only with hormonal replacement, Belt declared that "if we had transplanted either one or both testicles into the abdomen . . . maintaining their blood supply, and virtually transforming the testis into a crypt organ, there would have been no

[114] Elmer Belt to Karl Bowman, August 15, 1960, Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC.

physiological upset."[115] Whereas Stoller and Solomon saw an intersexed patient in Agnes, her later revelation confirmed Belt's suspicion: Agnes's gonadal physiology carried the biological secret to her true transsexualism and the potential balance to the unexpected menopausal symptoms. Belt ultimately gained something in losing this battle over castration. Similar to the way it served as a tipping point in Stoller's reconceptualization of gender, the case of Agnes enabled Belt to yield an exemplary narrative to which he could return in order to uphold his cryptorchidism principle.[116]

With respect to Agnes's sense of self, one might consider it a bona fide transgender identity all along. However, the opacity between an intersex versus transsexual embodiment that she leveraged calls into question the stability of transness in her evolving encounter with the medical professionals. This bears semblance to the skepticism in the reciprocal interaction between doctors and E. H. around the same time. While Agnes's story may have served to confirm a biological version of gender identity theory at one time and a psychoanalytic definition at another, it also raised interesting, unresolved questions about the need and consequence of castration in MTF transsexual surgeries from the urological angle as proposed by Belt. What tipped Agnes to reveal the "truth"—whether about the uncertainty of scientific understandings or regarding the ruse of patient authority—has escaped most of the scholarly attention to date. Belt's involvement in this case, especially the theoretical feasibility of his cryptorchidism

[115] Ibid.

[116] See also Elmer Belt to Harry Benjamin, July 1, 1960, Elmer Belt, 1959–1962 folder; Elmer Belt to Burton H. Wolfe, March 24, 1969, Elmer Belt, 1965–1971 folder, both in box 3, series IIC, HBC.

technique, pushes back the assumption that her deliberate revelation settles once and for all the relevant scientific conclusions.

Transing Castration

From 1953 on, Belt carried out surgeries for a total of twenty-nine MTF patients. Out of the twenty-five patients on whom Belt operated after 1956, all but one had their testes transplanted into the abdomen. It is unclear why Belt decided to take out the testicles of this particular patient, but his record suggests that it might have had something to do with a carcinoma of the prostate.[117] On September 1962, Belt performed his last genital operation on a twenty-seven-year-old patient who came from outside Benjamin's network. In the following month, he announced that he would no longer take on cases of sex conversion. He was partly reacting to a cautionary tale, told by Benjamin at a luncheon about a professional acquaintance who had been sued for a million dollars by a patient. Even though Belt was confident that he could defend himself adequately if faced with such a lawsuit, he worried that the entire profession would turn against him, bringing his repute to a level of damage beyond repair. His close friends had "heart-to-heart" talks with him, worrying about the gossips about him and his practice. One day his wife and his son, Bruce Belt, sat down with him and "protested so loudly over the care of transsexual

[117] Elmer Belt to Harry Benjamin, April 15, 1963, Elmer Belt, 1962–1965 folder, box 3, series IIC, HBC.

patients" that he agreed to stop.[118] In the 1960s, he noticed a growing number of alternative surgical destinations, both domestic and international.[119]

This episode in sexual science suggests that in the decade after the Kinsey bomb and the publicity showered on Jorgensen, some doctors worked quietly on creating opportunities for sexual minorities.[120] Though bold in his surgical technique and adamant in defending it, Belt had a vested interest in protecting his professional reputation throughout the 1950s and 1960s, as well as his legacy afterward. He once complained to Bowman that the majority of his medical peers were so close-minded "because they fear that some of the smudge will come off on them as men try to make it do on Kinsey."[121] In 1969, a reporter approached Belt to uncover the history of his contribution to transsexual care.[122] But the reporter, in relying on secondary and tertiary informants, annoyed Belt by grossly misconstruing the details of his practice, including the accusation that Belt had ceased to perform conversion surgeries under pressure from the district

[118] Elmer Belt to Harry Benjamin, October 16, 1962, Elmer Belt, 1962–1965 folder, box 3, series IIC, HBC.
[119] Meyerowitz, *How Sex Changed* (n. 1), 147. Harry Benjamin to Elmer Belt, October 25, 1966, Elmer Belt, 1965–1971 folder, box 3, series IIC, HBC.
[120] The Kinsey bomb refers to the staggering findings by Alfred Kinsey's research team at Indiana University on the high incidence of variation in male and female sexual behavior. These findings shocked the public and reoriented scientific conceptions of norms in the early Cold War era. See, for example, Sarah Igo, *The Average American: Surveys, Citizens, and the Making of a Mass Public* (Cambridge, Mass.: Harvard University Press, 2007); Howard Chiang, "Effecting Science, Affecting Medicine: Homosexuality, the Kinsey Reports, and the Contested Boundaries of Psychopathology in the United States, 1948–1965," *J. Hist. Behav. Sci.* 44, no. 4 (2008): 300–318; Donna J. Drucker, *The Classification of Sex: Alfred Kinsey and the Organization of Knowledge* (Pittsburgh: University of Pittsburgh Press, 2014).
[121] Elmer Belt to Karl Bowman, September 6, 1960, Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC.
[122] Burton H. Wolfe to Elmer Belt, March 10, 1969, Elmer Belt, 1965–1971 folder, box 3, series IIC, HBC.

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attorney and the County Medical Association.[123] It was in the name of science, then, that we can best understand why Belt recited the details of his exemplar, Agnes, once again to this reporter. Now suggesting, as Stoller did, that Agnes's deception had prevented him from gathering reliable evidence, Belt told an unsuccessful story of a scientist who succeeded in helping others.[124]

Given the importance of the Agnes case to Elmer Belt's surgical approach, it might seem surprising that his involvement has received so little scholarly attention. One possible reason lies in the fact that Belt published next to nothing on the subject of transsexuality and sex-reassignment surgery. The documentation of his thinking on the cryptorchidism technique mostly transpired in personal correspondences with other physicians. In July 1960, Belt told Benjamin that he considered the sex conversion cases "all very interesting," but he had "not attempted to write about them because I feel that my knowledge is too meager. Had I your deep and broad knowledge of the endocrinological aspects of this field I should be more bold."[125] When Benjamin asked him to contribute a chapter on surgical technique for *The Transsexual Phenomenon* in early 1964, Belt initially agreed.[126] This promise never materialized, however. The manuscript that reached Julian Press in 1966 contained a general section on operations written by Benjamin himself.[127] In fact, the entire discussion of castration in *The Transsexual*

[123] Burton H. Wolfe to Elmer Belt, March 25, 1969; Elmer Belt to Burton H. Wolfe, March 31, 1969, both in Elmer Belt, 1965–1971 folder, box 3, series IIC, HBC.
[124] Elmer Belt to Burton H. Wolfe, March 24, 1969, Elmer Belt, 1965–1971 folder, box 3, series IIC, HBC.
[125] Elmer Belt to Harry Benjamin, July 1, 1960, Elmer Belt, 1959–1962 folder, box 3, series IIC, HBC.
[126] Harry Benjamin to Elmer Belt, January 10, 1964; Elmer Belt to Harry Benjamin, January 27, 1964, both in Elmer Belt, 1962–1965 folder, box 3, series IIC, HBC.
[127] Harry Benjamin, *The Transsexual Phenomenon* (New York: Julian Press, 1966), 100–104.

Phenomenon centered on why some surgeons and, to a lesser extent, patients preferred to preserve the testicles. "The reason," wrote Benjamin, "is chiefly endocrine, based on the theory that the teste in transsexual men may produce more estrogen than they do normally."[128]

Today, transsexual narratives often privilege "the transformation of one normative genital morphology into another normative genital morphology."[129] Even though we tend to think of castration operations as either an antecedent to or part of a full sex change surgery, Belt's approach queerly represents the opposite. This is where the historical uncertainty in the definition of transness becomes most readily evident. More recently, the clinical record shows that some individuals experience intense castration ideations and embody a modern-day eunuch identity after castration operations.[130] That these contemporary eunuchs tend to occupy a social position distinct from the notion of *transgender* demands a rethinking of this latter term, its historicity, and its culturally circumscribed criteria of inclusion and exclusion. To borrow the insight of sociologist Clare Sears, a "trans-ing analysis" can help us reframe castration with respect to how "problem bodies" have been created at different points in time.[131] As this article has shown, scientists, clinicians, and patients were far from uniform in their conceptualization of what "sex change" operations entailed into the 1960s. A largely forgotten surgical logic of trans embodiment emerged from the juncture of these doctor-patient uncertainties. Elmer Belt's foray

[128] Ibid., 100.
[129] Stryker and Sullivan, "King's Member" (n. 13), 55.
[130] Richard J. Wassersug and Thomas W. Johnson, "Modern-Day Eunuchs: Motivations for and Consequences of Contemporary Castration," *Perspect. Biol. & Med.* 50, no. 4 (2007): 544–56; Richard J. Wassersug, Emma McKenna, and Tucker Lieberman, "Eunuch as a Gender Identity after Castration," *J. Gender Stud.* 21, no. 3 (2010): 253–70.
[131] Clare Sears, *Arresting Dress: Cross-Dressing, Law, and Fascination in Nineteenth-Century San Francisco* (Durham, N.C.: Duke University Press, 2015).

into sex reassignment surgeries demonstrates that anti-castration thinking once dominated transsexual science. However, it would be frivolous to leave his uncastrated patients out of trans history, similar to the exclusion of modern eunuchs from the radical queer and transgender community today. These historical referents provide a "useable past" to diversify the meaning and future of transness.[132]

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[132] Van Wyck Brooks, "On Creating a Useable Past," *The Dial* 64, no. 7 (1918): 337–41.